Department of Behavioral Health

TRANSMITTAL LETTER

SUBJECT Informed Consent for Behavioral Health Treatment for Adults Receiving Services in the Community		
POLICY NUMBER DBH Policy 414.2	DATE SEP 0 8 2017	TL# 311

Purpose. The purpose of this policy is to clarify the informed consent process for providing outpatient behavioral health services and supports to adults, including prescribing psychiatric medications and medication assisted treatment (MAT).

Applicability. This policy applies to DBH and to all Department of Behavioral Health (DBH) certified providers with a Human Care Agreement that are providing behavioral health services and supports to people over the age of eighteen (18).

Policy Clearance. Reviewed by affected responsible staff and cleared through appropriate Behavioral Health Authority (BHA) offices and providers (see applicability above).

Effective Date. This policy is effective immediately.

Superseded Policy. This policy replaces DMH Policy 414.2, Informed Consent for Mental Health Treatment for Adults Receiving Services in the Community, dated Feb. 14, 2011.

Distribution. This policy will be posted on the DBH web site at www.dbh.dc.gov under Policies and Rules. Applicable entities are required to ensure that affected staff is familiar with the contents of this policy.

Tanya A. Royster, M.D. Date 9/8/201
Director, DBH

GOVERNMENT OF THE DISTRICT OF COLUMBIA DEPARTMENT OF BEHAVIORAL HEALTH	Policy No. 414.2	Date SEP 0 8 2017	Page 1
	Supersedes DMH Policy 414.2 Informed Consent for Behavioral Health Treatment for Adults Receiving Services in the Community dated February 14, 2011		

Subject: Informed Consent for Behavioral Health Treatment for Adults Receiving Services in the Community

1. **Purpose**. The purpose of this policy is to clarify the informed consent process for providing outpatient behavioral health services and supports to adults, including prescribing psychiatric medications and medication assisted treatment.

2. **Applicability**. This policy applies to all Department of Behavioral Health (DBH or the Department) certified providers with a Human Care Agreement that are providing behavioral health services and supports to people over the age of eighteen (18).

3. **Authority**. Department of Behavioral Health Establishment Act of 2013 (D.C. Official Code § 7-1141.02); Consent to Mental Health Services and Mental Health Supports (D.C. Official Code § 7-1231.07); Administration of Medication (D.C. Official Code § 7-1231.08); 22 DCMR A1, Consent to Treatment; 22A DCMR, Chapter 34, Mental Health Rehabilitation Services Certification Standards; and, 22A DCMR, Chapter 63, Certification Standards for Substance Use Disorder Treatment and Recovery Support Providers.

4. **Policy**. DBH-certified providers shall obtain and document acquiring informed consent from an individual before delivering behavioral health treatment, including treatment with medications. Informed consent is not required during an emergency (see Section 6).

5. **Definitions.**

5a. Individual. A person eighteen (18) years of age or older who is eligible to receive behavioral health services and supports as defined in § 102 of the Act (D.C. Official Code § 7-1131.02(18) and (19)).

5b. DBH-Certified Provider. Any individual or entity, public or private, providing services to individuals in the community, which is licensed or certified by the Department to provide behavioral health services and behavioral health supports, and has entered into an agreement with DBH to provide behavioral health services and supports.

5c. Emergency. A situation in which an individual is experiencing a behavioral health crisis in which the immediate provision of behavioral health treatment to prevent serious injury to the individual or others.

5d. Informed Consent. Consent voluntarily given for behavioral treatment after the behavioral health provider presents him or her with information about the proposed behavioral health services, behavioral health support, or treatment, in a language and manner that the individual can understand.

5e. Medication Assisted Treatment (MAT). The use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders. For example, one form of MAT uses methadone as a pharmacotherapy for long-term treatment for opiate or other forms of dependence.

5f. Substitute Health Care Decision-Maker. An individual authorized to make medical decisions on behalf of an individual who lacks the capacity to make or communicate his or her own medical decisions (See Section 7).

6. **Procedures.**

6a. Each provider shall obtain informed consent to treatment from each individual receiving behavioral health services or supports from the provider before implementing the individual's treatment plan. Informed consent to treatment shall be written.[1] If the individual is unwilling or unable to sign a consent to treatment form, then the provider shall document the reason in the individual's clinical records.

6b. To be able to give informed consent, an individual must be capable of making and communicating a decision about the proposed behavioral health treatment or service. The information provided to an individual must be in a method and manner that he or she can understand and shall include an explanation of:

(a) An individual's behavioral health illness, including diagnosis;

(b) The purpose of the proposed behavioral health service, support, or treatment;

(c) The name and dosage of medication prescribed, if that is a proposed treatment;

(d) The known and potential common side effects or risks of the proposed behavioral health service, support, or treatment;

(e) The potential benefits of the proposed behavioral health services, supports, or treatment; and,

[1] Written informed consent may be in the form of formalized signed Informed Consent Form that includes the elements found in Exhibit 1 – Informed Consent to Behavioral Health Treatment (For Adults), Exhibit 2 – Informed Consent to the Use of Psychiatric Medication(s) (For Adults) and Exhibit 3 – Informed Consent to the Use of Medication Assisted Treatment (For Adults), or, as documented by the DBH-certified provider in the individual's clinical record (i.e., progress notes). The DBH-certified provider must justify the lack of written documentation of informed consent to behavioral health treatment by the individual or substitute decision-maker in writing.

(f) Any feasible alternatives to the proposed behavioral health services, supports, or treatment. [2]

6c. If an individual has the capacity to make health care or treatment decisions and refuses behavioral health treatment, the behavioral health provider shall document the refusal in his or her clinical record.

6d. If an individual verbally consents to the recommended medications, but refuses to sign a consent form, the prescriber shall record the attempts (See Exhibit 2, Informed Consent to the Use of Psychiatric Medications – Adults or Exhibit 3, Informed Consent to the Use of Medication Assisted Treatment – Adults), on the consent form or document the informed consent in the individual's clinical records.

6e. If an individual who has given informed consent to treatment decides that he or she no longer consents to this treatment, the behavioral health provider shall document the decision in his or her clinical record. A behavioral health provider may not continue to provide a specific behavioral health treatment to an individual who withdraws his or her consent to that particular form of treatment.

6f. An individual who is eighteen (18) years old or older who is receiving behavioral health services and supports in the community is presumed to have the legal capacity to make treatment decisions unless:

(1) A court has declared the individual incompetent to make treatment or health care decisions and has appointed a guardian to make such decisions (see Section 7);

(2) It has been determined that the individual lacks the capacity to make a health care decision (see Section 8); or

(3) A court has explicitly ordered an individual to participate in a specific form of behavioral health treatment or to take medication.

7. **Informed Consent Not Required in an Emergency.**

7a. If an emergency exists, a DBH-certified provider shall obtain a written opinion from the individual's attending physician stating that delay in obtaining informed consent to the behavioral health services, behavioral health supports or treatment is likely to result in serious injury to the individual (Emergency Opinion).

7b. If the DBH-certified provider has information that the individual would not consent to emergency treatment based on his or her religious beliefs, the provider must obtain a court order before administering the treatment that would terminate the emergency.

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[2] See Exhibit 1, a DBH sample form for behavioral health treatment, Exhibit 2, a DBH sample for psychiatric medication and Exhibit 3 sample form for medication assisted treatment; however, the provider may use its own form containing the required elements.

7c. After receipt of the Emergency Opinion, the DBH-certified provider shall provide behavioral health services, behavioral health supports or treatment to the extent necessary to terminate the emergency.

8. **Informed Consent from Substitute Decision-maker.**

8a. When a DBH-certified provider believes that an individual lacks sufficient capacity to appreciate the nature and implications of a behavioral health-care decision, make a choice regarding the alternatives presented, or unambiguously communicate that choice, the provider may seek certification of the individual incapacitation.

(1) Certification of incapacity to make a treatment decision requires a determination by two physicians, one of whom shall be the individual's treating psychiatrist, that the individual lacks the capacity to understand the decision to be made or to make or communicate a decision about the proposed treatment.

(2) An individual shall not be deemed incapacitated if her or she is capable of understanding the decision to be made or making the decision and communicating the decision, but refuses to provide consent to a proposed treatment or makes a decision different than the provider would prefer.

8b. If an individual has been certified as incapacitated in accordance with D.C. Official Code § 21-2204, the provider shall seek informed consent to the proposed behavioral health service, behavioral health support or course of treatment as follows:

(1) From the individual's designated attorney in-fact, if he or she has executed a valid durable power of attorney for health care or

(2) From a substitute health care decision-maker in accordance with D.C. Official Code § 21-2210.

8c. If an individual has been certified as incapacitated in accordance with D.C. Official Code § 21-2204 and the provider is not able to obtain informed consent from either a designated attorney-in-fact or a substitute health care decision-maker, the provider shall petition the court for appointment of a guardian appointed by the court.

8d. A provider shall seek appointment of a guardian for an individual in accordance with subchapter V of Chapter 20 of Title 21 of the District of Columbia Official Code, if:

(1) An individual remains incapacitated for purposes of making a particular health care decision for more than thirty (30) days following certification of incapacitation; and

(2) The individual does not have an attorney-in-fact designated in a durable power of attorney document available to make decisions about the delivery of behavioral health services, behavioral health supports or treatment to the individual.

8e. The substitute health care decision-maker responsibilities are as follows:

(1) Act in accordance with the individual's treatment preferences as expressed in an advance directive or a declaration of advance instructions.

(2) Make a decision regarding behavioral health treatment which is based on the individual's expressed treatment preferences, except for good cause as documented in his or her clinical records, and shall never be overridden for the convenience of the provider.

(3) In the absence of an advance directive or declaration of advance instructions, grant, refuse or withdraw consent to behavioral health treatment based on the known wishes of the individual or, if the wishes of the individual are unknown and cannot be ascertained, on a good faith belief as to the best interests of the individual per D.C. Official Code § 21-2210(b).

(4) May consent to the administration of medication for the individual only in accordance with the individual's treatment preferences as expressed in a durable power of attorney document or in a declaration of advance instructions for behavioral health treatment.

8f. A provider shall document whether the substitute health care decision-maker grants, refuses or withdraws consent to behavioral health treatment on behalf of an individual in the individual's clinical record.

8g. At least one (1) witness shall be present whenever a substitute health care decision-maker grants, refuses or withdraws consent to treatment on behalf of an individual.

9. **Responsibilities of DBH-Certified Providers.**

9a. Establish internal policies and procedures. A provider shall establish policies and procedures in compliance with this policy to ensure informed consent is obtained before providing behavioral health treatment.

9b. Document informed consent (e.g. forms). A DBH-certified provider shall use the DBH forms for informed consent or its own forms as long as the required elements are included. Documentation of informed consent must be maintained in the individual's clinical record.

9c. Provide information and education. Familiarize individual or, as applicable, substitute health care decision-makers or power-of-attorney holders, and their family members about behavioral health medications, including psychiatric medications and medication assisted treatment, and effectiveness and possible side effects.

9d. Maintain records for incapacitated individuals. If an individual has been determined to be incapacitated in accordance with D.C. Official Code § 21-2204, the provider should maintain within the individual's records the certificates of incapacity, the guardianship or power-of-attorney documentation (if applicable), or other information on the individual's substituted-health care decision-maker as identified in accordance with D.C. Official Code § 21-2210.

10. **Exhibits.**

Exhibit 1: Informed Consent to Behavioral Health Treatment (For Adults)
Exhibit 2: Informed Consent to the Use of Psychiatric Medication(s) (For Adults)
Exhibit 3: Informed Consent to the Use of Medication Assisted Treatment (For Adults)

Approved By:

Tanya A. Royster, MD
Director, DBH

(Signature) 9/8/2017 **(Date)**

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

INFORMED CONSENT TO BEHAVIORAL HEALTH TREATMENT (For Adults)

IMPORTANT: Please read carefully before signing this form. Before signing this form, the behavioral health provider(s) must explain the behavioral health treatment(s) available to you.

I hereby consent to receive behavioral health treatment from _____
(Behavioral Health Provider)

for the purpose of treating mental health, substance use disorder, or co-occurring symptoms or illnesses. I understand that I will receive additional information about the purpose, side effects and potential risks and benefits, and information about feasible alternative treatments throughout the duration of my treatment.

_____ _____ _____
Printed Name of Individual Individual's Signature Date

If an individual has been certified as incapacitated, the attorney-in-fact or a substitute health care decision-maker shall complete the portions below:

I have the legal right to accept or refuse behavioral treatment for

_____,
Print Individual's Name

and I hereby consent to him/her receiving behavioral health treatment for the purpose of addressing mental health, substance use disorder, or co-occurring symptoms or illnesses.

_____ _____
Printed Name Date

_____
Signature

_____
Relationship to Individual

IMPORTANT NOTE: Documentation establishing informed consent to behavioral health treatment shall be maintained in the individual's clinical records.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

INFORMED CONSENT FOR USE OF PSYCHIATRIC MEDICATION(S)
(For Adults)

Instructions for DBH Form 145

Purpose:

1. To serve as a legal record of the individual's informed consent to take psychiatric medication as part of a treatment regimen; and,

2. To document that the individual has been offered information about the medications being prescribed.

Instructions

1. The individual received information about the medication(s) before completing the form.

2. Up to three (3) medications can be listed on this form, each of which the individual shall consent to using.

3. Enter the medication(s) and dosage range(s) into the table.

4. The individual shall initial and date any modifications to dosages for prescribed medications. Whenever the prescriber suggests a new medication(s), a new form shall be used. .

5. If the individual consents to medications, check the applicable box.

   a. If the individual agrees, then her or she and the prescriber shall sign and date the form.

   b. If the individual cannot or will not sign, the prescriber shall fill out the form and include the reason why the individual did not sign the form and shall sign and date the form before a witness who shall also sign the form.

   c. If the individual is willing to document his or her refusal of medications, this box should be checked and the prescriber and individual can sign and date at the bottom.

6. If the individual signs with a mark, a witness is needed.

7. An individual may withdraw consent at any time by notifying the prescriber. The reason for the withdrawal should be documented in the progress notes, and the medication order should be discontinued.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

INFORMED CONSENT FOR USE OF PSYCHIATRIC MEDICATION(S)
(For Adults)

Printed Individual's Name:_____ Date of Birth: _____

Reason for Treatment:_____

Please check one of the following:

( ) I have had the opportunity to receive information about my medications from the prescriber, and I consent to this treatment. I understand I can ask questions about my medicines at any time. The information includes the following: name and dose of the medication, purpose; potential common side effects, risks and benefits and feasible alternatives.

( ) I have had the opportunity to discuss information about the medications with the prescriber, and I **refuse** to consent to the medications recommended. I understand that my doctor will continue to offer me the chance to take medicine, and information about it, but that I may still continue to refuse the medicine.

( ) Individual verbally consents to the recommended medications, but refuses to sign because:

_____

Record of attempts: Initials of Prescriber_____ Date_____
Initials of Prescriber_____ Date_____

Medication Name	Route (√ below)		Daily Dose Range	For Modification:			
	Oral	Inject		Date	Individual Initials	Date	Individual Initials

_____ _____ _____
Individual's Name Individual's Signature Date

_____ _____ _____
Substitute Decision-Maker's Name Substitute Decision-Maker's Signature Date

_____ _____ _____
Authorized Prescriber's Name & Credentials Authorized Prescriber's Signature Date

IMPORTANT NOTE: Documentation establishing informed consent to mental health services, mental health support, or treatment shall be maintained in the individual's clinical records.

GOVERNMENT OF THE DISTRICT OF COLUMBIA
Department of Behavioral Health

INFORMED CONSENT FOR USE OF MEDICATION ASSISTED TREATMENT
(For Adults)

Individual's Name: _____ Date of Birth: _____

Diagnoses:

ICD-10-CM	

I, _____ have been given information by my medical
(Printed Name of Individual),

practitioner about the medications listed below. For each medication listed below, I have been given the opportunity to discuss with my prescriber the following:

- The diagnosis and target symptoms for the medication recommended.
- The possible benefits and intended outcome of treatment.
- The possible results of not taking the recommended medication.
- The dosage and the possibility that my medication dose may need to be adjusted over time, in consultation with my medical practitioner.
- The possible risks and side effects.
- My right to withdraw voluntary consent for medication at any time (unless the use of medications in my treatment are required in a Court Order)
- The possible alternatives.
- The medication may be used "off-label" for a particular condition (in the absence of FDA approval) and that the medical practitioner will indicate when a medication is being used in this manner.[1]

I understand that the medication information provided to me and my signature below acknowledges that I consent to the use of these medications.

Medication Name	Route	Dosage

_____	_____	_____
(individual's name)	(individual's signature)	date
_____	_____	_____
(substitute decision-maker's name)	(substitute decision-maker's signature)	date
_____	_____	_____
(prescriber's name)	(prescriber's signature)	date

[1] Off-label drug use involves prescribing medications for indications or using a dosage or dosage form, which has not been approved by the U.S. Food and Drug Administration.